

Background

On Friday, December 5, 2014, the Centers for Medicare and Medicaid Services (CMS) released a final rule on Medicare provider enrollment requirements. The provisions of the final rule, *Requirements for the Medicare Incentive Reward Program and Provider Enrollment*, are set to become effective on February 3, 2015. The final rule is in response to a proposed rule CMS issued on April 29, 2013.

While the rule title references the [Medicare “Incentive Reward Program,”](#) a program designed to encourage individuals to report fraud to Medicare, CMS did not finalize any of the related provisions, although stated that it might do so in future rulemaking. CMS only finalized and discussed its proposals related to provider enrollment.

A copy of the final rule can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2014-12-05/pdf/2014-28505.pdf>. Page numbers in this summary refer to the *Federal Register* page numbers.

Highlights of the Final Rule

Enrollment Clarifications (p. 72501). As directed under the ACA, Medicare has required providers to “enroll” in Medicare even if only for the purpose of ordering or certifying items or services for Medicare beneficiaries. This is a separate process from “enrolling” for billing privileges for services provided to Medicare beneficiaries. In order to clarify the difference between the two enrollment categories, CMS finalized three changes:

- **Definition of “Enroll/Enrollment”:** CMS now defines “enroll/enrollment” as “the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, **and the process that Medicare uses to establish eligibility to order or certify for Medicare-covered items and services.**” (Emphasis added).
- **Definition of Granting Privileges:** CMS finalized the inclusion of language that now states “Except for those suppliers that complete the CMS-8550 form or CMS-identified equivalent or successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, granting the Medicare provider or supplier Medicare billing privileges.”
- **Enrollment Privileges:** Previous regulatory language had stated that if a provider “enrolled” that billing privileges were granted. Because of the alternate “ordering or certifying” enrollment process, CMS updated the language to state, “Except for those suppliers that complete the CM-8550 or CMS-identified equivalent or successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, once enrolled the provider or supplier receives billing privileges and is issued a valid billing number effective for the date a claim was submitted for an item that was furnished or a service that was rendered.”

In addition,

- CMS stated that it reserves the right to require individuals who are enrolled solely to order and certify items or services to revalidate their enrollment information every 5 years.
- When asked for clarification as to whether a physician must have a valid enrollment record in PECOS to order infusion and nebulizer drugs or other Part B drugs, CMS only stated that the comment and request for clarification was outside the scope of the final rule.

- CMS stated that at a later date it might require inclusion of practice location for purposes of enrollment for ordering and certifying.

Denial of Enrollment: Previous Medicare Debt (p. 72505). Under previous regulation, CMS was allowed to deny enrollment to anyone who “has an existing overpayment at the time of filing of an enrollment application.” This was to prevent an owner of a provider or supplier who (with payments owed to Medicare) exits the Medicare program and attempts to re-enroll as a different entity. CMS made its proposed changes because it was concerned that its authority was limited to “situations where an enrolling physician, non-physician practitioner, or an owner of the enrolling provider or supplier has a current Medicare overpayment” and does not apply when the enrolling provider or supplier entity has a current debt (overpayment or other financial obligation). The current language also did not address cases where an entity with which the enrolling provider, supplier, or owner was affiliated had incurred the debt. CMS finalized changes:

- To ensure the provision applies to “all providers, suppliers (including physicians and non-physician practitioners), and owners thereof.”
- To allow for avoidance of enrollment denial in exchange for an extended CMS-approved repayment schedule (or by repaying the debt in full).
- To replace the word “overpayment” with “Medicare debt.”
- To allow for enrollment denial “if the provider, supplier or current owner . . . thereof was the owner . . . of a provider or supplier that had a Medicare debt that existed when the latter’s enrollment was voluntarily or involuntarily terminated or revoked, and the following criteria are met:
 - The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier’s voluntary termination, involuntary termination, or revocation.
 - The Medicare debt has not been fully repaid.
 - [CMS] determine[s] that the uncollected debt poses an undue risk of fraud, waste, or abuse.”

Denial of Enrollment/Revocation of Billing Privileges: Federal or State Felony Convictions (p. 72509). Current regulations allow for Medicare denial or revocation of enrollment if the provider or supplier (or owner of the provider or supplier) has, within the last 10 years been convicted of a federal or state felony offense. CMS finalized its proposal to expand the categories of felonies that can serve as the basis for denial or revocation and clarified that any felony conviction that it considers detrimental to the best interests of the Medicare program and its beneficiaries could serve as a basis for enrollment denial or revocation. In addition, CMS will also apply the requirements to “managing employees” under the rationale that certain managing employees could have as much (or more) day-to-day control as the owner. In addition, in order to reduce confusion on the timeframe for evaluation, CMS changed “within the 10 years preceding enrollment or revalidation of enrollment” to “within the preceding 10 years.”

Revocation of Billing Privileges: Pattern or Practice of Non-Compliant Medicare Claims and “Abuse of Billing Privileges” (p. 72513). Current regulations state that

[A] provider or supplier’s Medicare billing privileges may be revoked if the provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include, but are not limited to, situations where the beneficiary is deceased, the directing physician or beneficiary is not in the state or country when the service was provided, or when the equipment necessary for testing was not present where the testing is said to have occurred.

CMS finalized its proposal to alter the language to more easily allow Medicare to revoke enrollment status for the “abuse of billing privileges” for those that have a pattern or practice of submitting claims that do not meet Medicare requirements. The language will now read:

Abuse of Billing Privileges. Abuse of billing privileges includes either of the following:

- (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:
 - (A) Where the beneficiary is deceased.
 - (B) The directing physician or beneficiary is not in the state or country when services are furnished.
 - (C) When the equipment necessary for testing is not present where the testing is said to have occurred.
- (ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
 - (A) The percentage of submitted claims that were denied.
 - (B) The reason(s) for the claim denials.
 - (C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under §424.502) and the nature of any such actions.
 - (D) The length of time over which the pattern has continued.
 - (E) How long the provider or supplier has been enrolled in Medicare.
 - (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

Revocation of Billing Privileges: Submission of Remaining Claims (p. 72520). Current regulation requires “a revoked physician organization, physician, non-physician practitioner or IDTF” to submit all claims for furnished services within 60 days of the effective date of the revocation. CMS finalized its proposal to require claims submission within 60 days of revocation for *all* revoked providers and suppliers. The provision adds additional language that applies to home health agencies (HHAs) that states that the date would be 60 days after the later of either the effective date of the revocation or the date that the HHAs last payable episode ends.

Revocation of Billing Privileges: Re-Enrollment Bar (p.72522). When a provider or supplier has its enrollment revoked, the provider or supplier is barred from re-enrolling for at least 1 year and no more than 3 years. CMS revised its regulations to indicate that all re-enrollment bars begin 30 days after CMS or its contractor mails notice of a revocation determination to a provider or supplier. This was to address previous language that calculated the time differently for revocations based on a federal exclusion or debarment, felony conviction, license suspension or revocation, or if the practice location is determined by CMS or its contractor not to be operational.

Revocation of Billing Privileges: Limitations on Submission of Corrective Action Plans (p.72523). Under current regulation, a provider or supplier that has billing privileges revoked can submit a corrective action plan (CAP). If Medicare determines that the provider or supplier is compliant with Medicare requirements, billing privileges can be reinstated. CMS finalized its proposal that only allows for use of a CAP to have billing privileges reinstated when the reason for revocation was that the provider was not in compliance with Medicare enrollment requirements. For other reasons for revocation, the provider or supplier would not be able to avail itself of the CAP process in order to have billing privileges be reinstated.

Billing Privileges: Ambulance “Back Billing” (p. 72521). Current Medicare regulations allow newly enrolling physicians, non-physician practitioners, and physician and non-physician practitioner organizations to submit claims as of either (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or non-physician practitioner first began furnishing services at a new practice location. CMS has maintained this rule to ensure that the Medicare program is not billed for services before either of those dates. CMS finalized its proposal to extend this to ambulance suppliers.

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